

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355082	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2009
NAME OF PROVIDER OR SUPPLIER AVE MARIA VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 501 19TH ST NE JAMESTOWN, ND 58401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS This survey used the 2000 edition of NFPA 101, Life Safety Code, Chapter 19 Existing Health Care Occupancies, in compliance with 42 CFR 483.70(a) and NDAC 33-07-04.2-09(1)(c). The facility is located in a one-story building of Type V (000) construction with a partial basement. The building was equipped with a wet automatic sprinkler system with quick response sprinklers designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems. The facility was divided into three smoke zones; A & B Wing (resident sleeping rooms), C & D Wing (resident sleeping rooms), and Service Wing (central nurses station, dining room, therapy, and kitchen). An assisted living complex was attached to the west side of the nursing facility and was separated by an occupancy separation wall having a two-hour fire resistance rating. At the conclusion of the LSC survey it was determined the facility was in compliance with the standards.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.